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DESOTO COUNTY, MS
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DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Notice to Person Executing This Document

This is an important legal document. Before executing this document, you should know these important facts:

This document gives the person you designate as the attorney in fact (your agent) the power to make health care decisions for you. This power exists only as to those health care decisions to which you are unable to give informed consent. The attorney in fact must act consistently with your desires as stated in this document of otherwise made know.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you alive may not be stopped or withheld if you object at the time.

The document gives your agent authority to consent, to refuse to consent or to withdraw consent to care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition. This power is subject to any statement of your desires and nay limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a Court can take away the power of your agent to make health care decisions for you if your

agent (a) authorizes anything that is illegal, (b) acts contrary to your known desires, or (c) where your desires are not known, does anything that is clearly contrary to your best interest.

You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital or other health care provider in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

Unless you otherwise specify in this document, this document gives your agent the power after you die to (a) authorize an autopsy, (b) donate your body or parts thereof for transplant, or for educational, therapeutic or scientific purposes, and (c) direct the disposition of your remains.

If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.

This power of attorney will not be valid for making health care decisions unless it is either (a) signed by two (2) qualified adult witnesses who are personally known to you and who are present when you sign or acknowledge your signature or (b) acknowledged before a notary public in this state.

1. DESIGNATION OF HEALTH CARE AGENT. (A treating health care provider or an employee of a treating health care provider may not be named as your Attorney-in-Fact.) I,Anita Coleman Aiken White, of 3199 Hwy 51 South, Hernando, DeSoto County, Mississippi 38632 hereby appoint

Elizabeth Jean Aiken Odom (agent name)
36 Old Hwy 11, Evening Shade, Sharp County, Arkansas 72532
or P.O. Box 127, Evening Shade, Arkansas 72532 (agent address)
(H) 870-266-3060 (C) 901-326-0160 (phone)
Daughter (relation)

as my Attorney-in-Fact to make health care decisions for me if I become unable to give informed consent for my own health care decisions. This document gives my Attorney-in-Fact the power to consent, refuse to consent, or withdraw consent on my behalf for my health care, treatment, services, or procedure to maintain, diagnose, treat a physical or mental condition.

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE By this document I intend to create a Durable Power of Attorney for Health Care effective upon, and only during, any period of incapability in which, in the opinion of my agent and my attending physician, I am unable to make or communicate a choice regarding a particular health care decision. This power of attorney shall take effect upon my disability, incapacity, or incompetency, and shall continue during such disability, incapacity, or incompetency.

3. GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to my special instructions below, this document gives my Attorney-in-Fact ("agent") the full power to make health care decisions for me, before or after my death, to the same extent I could make decisions for myself and to the full extent permitted by law, including power to grant, refuse or withdraw consent on my behalf for any health care services, to make a disposition under the state's anatomical gift act, to authorize an autopsy, and to direct the disposition of my remains. My Agent also has the authority to talk to health care personnel, get information and sign forms necessary to carry out these decisions, and also the power provided in Sections 41-41-101 through 41-41-121, Mississippi Code of 1972, as now enacted or hereafter amended, being the statutes governing the withdrawal of life-savings mechanisms.

4. STATEMENT OF DESIRES CONCERNING LIFE-SUSTAINING CARE, TREATMENT, SERVICES AND PROCEDURES:

The powers granted above do not include the following powers or are subject to the following rules or limitations. With respect to life sustaining treatment, I direct the following:

A. I specifically direct my agent to follow my health care declaration of "living will" executed by me.

B. I do not want my life to be prolonged nor do I want life sustaining treatment to be provided or continued if my agent believes that the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved and the quality, as well as the possible extension of my life in making decisions concerning life sustaining treatment.

C. I do not want my life to be prolonged and I do not want life sustaining treatment: (1) if I have a condition that is incurable or irreversible and, without the administration of life sustaining treatment, expected to result in death within a relatively short time; or (2) if I am in a coma or persistent vegetative state which is reasonably concluded to be irreversible.

D. If at such time the situation should arise in which there is no reasonable expectation of my recovery from extreme physical or mental disability, I direct that I be allowed to die and not be kept alive by artificial means or "heroic measures". I do, however, ask that medication be mercifully administered to me to alleviate suffering, even though it could shorten my remaining life.

5. STATEMENT OF DESIRES CONCERNING NUTRITION AND FLUIDS. Artificially provided nutrition or fluids provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, (shall not be) among the "life-sustaining mechanisms" that may be withheld or withdrawn under the conditions given above.

6. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any limitations in this documents, my Agent has the power and authority to:

a. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records;

b. Consent to the disclosure of this information to others.

7. SIGNING DOCUMENTS, WAIVERS, AND RELEASES. Where necessary to implement the health care decisions that my Agent is authorized by this document to make, my Health Care Agent has the power and authority to execute on my behalf any of the following:

a. Documents to authorize my admission to or discharge (even against medical advice) from any hospital, nursing home, residential care or assisted living or similar facility or service;

b. Documents titled or purporting to be "Consent to Permit Treatment" or "Refusal to Permit Treatment"; or

c. Any necessary waiver or release from liability required by a hospital or physician.

8. AUTOPSY, ANATOMICAL GIFTS, DISPOSITION OF REMAINS. I authorize my Agent, to the extent permitted by law, to make anatomical gifts of part or all of my body for medical purposes, authorize an autopsy, and direct the disposition of my remains.

9. DURATION. I understand that this Durable Power of Attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this Durable Power of Attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself. This power of attorney ends on the following date: Indefinite.

10. SUCCESSORS. If any agent named by me shall die, become legally disabled, resign, refuse to act, be unavailable, or (if any agent is my spouse) be legally separated or divorced from me, I name the following (each to act alone and successively, in the order named) as successors to my agent:

William Russell Aiken, 1370 Holmes Road, Mountain View , Stone County, Arkansas 72560, (H) 870-757-2610 (C) 870-615-3387, son (name, address, phone, relation if any)

11. PRIOR DESIGNATIONS REVOKED. I revoke any prior Durable Power of Attorney for Health Care.

12. HOLD HARMLESS. All persons or entities who in good faith endeavor to carry out the terms and provisions of this document shall not be liable to me, my estate, my heirs or assigns for any damages or claims arising because of their action or inaction based on this document, and my estate shall defend and indemnify them.

13. SEVERABILITY. If any provision of this document is held to be invalid, such invalidity shall not affect the other provisions which can be given effect without the invalid provision, and to this end the directions in this document are severable.

14. STATEMENT OF INTENTIONS. It is my intent that this document be legally binding and effective. If the law does not recognize this document as legally binding and effective, it is my intent that this document be taken as a formal statement of my desire concerning the method by which any health care decision should be made on my behalf during any period in which I am unable to make such decisions.

15. NOMINATION OF CONSERVATOR. If a conservator should for nay reason be appointed, it is my desire that my health care attorney-in-fact should be appointed as my conservator.

By my signature I do hereby indicate that I understand the purpose and effect of this document.

Signed on the 15th day of February, 2010.

Anita Coleman Aiken White

Anita Coleman Aiken White
3199 Hwy 51 South
Hernando, Mississippi 38632
(H) 662-429-0036

NOTARY STATEMENT

STATE OF MISSISSIPPI

COUNTY OF DESOTO

On this the 15th day of February, in the year of 2010, before me, a Notary Public in and for said County and State, personally appeared the Principal, Anita Coleman Aiken White , proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to this instrument, and acknowledged that she executed it. I declare under the penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

SWORN TO AND SUBSCRIBED BEFORE ME on this the 15th day of February, 2010.

Sherry Hearington
Notary Public

(SEAL)
My Commission Expires:

STATE OF MISSISSIPPI NOTARY PUBLIC SHERRY HEARINGTON Commission Expires Aug. 14, 2012 DESOTO COUNTY